Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RENAISSANCE HOSPITAL HOUSTON
C/O BURTON & HYDE PLLC
PO BOX 684749
AUSTIN TX 78768-4749

Carrier's Austin Representative Box
#44

MFDR Date Received
OCTOBER 9, 2007

Respondent Name
OLD REPUBLIC INSURANCE CO

MFDR Tracking Number
M4-08-0968-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated October 3, 2007: "This bill should have been audited and reimbursed per the Stop-Loss reimbursement factor and methodology per the criteria as defined in TDI-DWC rule 134.401(c)(6)(A)…Per the stop-loss method the carrier should have reimbursed the provider $240,052.13."

Requestor's Supplemental Position Summary Dated March 24, 2011: "1. **The Audited charges in this case are $320,062.51.** 2. **The services provided by the hospital were unusually costly and unusually extensive**…because:

- **Complications.** [Claimant] experience complications. Post surgery he was placed in the ICU for a day for observation. [Claimant] had a high heart rate and low blood pressure. Blood work indicated [Claimant] had a very high hematocrit and an elevated white count. The attending physician, Kenneth Berliner, MD, diagnosed [Claimant] with hemoconcentration and hypovolemia. The attending physician prescribed a bolus of several liters of IV fluid for [Claimant], which he respond to and his condition improved.
- **Multiple surgeries.** As indicated in the hospital records, [Claimant] underwent multiple surgical procedures: procedure code 8106 – Lumbar and lumbosacral fusion of the anterior column, anterior technique; procedure code 7779 – Excision of bone for graft, other bones; procedure code 8108 – Lumbar and lumbosacral fusion of the anterior column, posterior technique; procedure code 8051 – Excision of intervertebral disc; procedure code 8162 – fusion or refusion of 2-3 vertebrae; procedure code 8451 – Insertion of interbody spinal fusion device, and procedure code 9979 – Other therapeutic apheresis.
- **Front-loaded costs**. The cost associated with the hospital's services in this case are front loaded-i.e. the injured employee underwent complicated surgical procedures requiring an investment in skilled professionals and advanced facilities and medical equipment.
- **Admission outside of the ordinary when compared to system-wide survey of Texas inpatient admission in 2005.** Unusually extensive services were provided during [Claimant's] hospital stay as indicated by the cost of this admission when compared to system-wide averages in the State of Texas. Data for all inpatient admissions in the Texas workers' compensation system was collected by the Department for 2005, 2006, 2007, 2008, and 2009. In 2007, the average bill for an inpatient admission was $39,766.32 and the average amount paid was $14,529.00. [Claimant's] admission was well outside of the ordinary when comparing the billed amount of $320,069.51 with system norms. It is even outside of the ordinary when considering the amount the carrier has already paid, $60,317.37, in light of the system averages. Of note, a principal diagnosis of 997.5 was rare in 2007; there were only two bills out of 9,703 identifying 997.5 as the principal diagnosis code. [Claimant] was the only hospital admission involving a

principal diagnosis code of 997.5 and a principal procedure code of 81.06. When compared to admissions system-wide [Claimant's] admission was out of the ordinary…For these reasons, the Medical Fee Dispute Officer should find that the second-prong of the two part test is satisfied and order additional reimbursement be paid by the carrier according to the stop-loss calculation methodology."

Amount in Dispute: $179,734.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated October 30, 2007: "The minimum Stop-Loss Exception threshold was not met and the Requestor failed to show that the surgery was unusually costly or extensive. Therefore, it has failed to meet the Stop-Loss criteria and no additional reimbursement is warranted…The Requestor has failed to explain how it supports its charges equaling $320,069.51 or its request seeking $179,734.76. The Requestor has failed to demonstrate that it billed its usual and customary charges for this stay, as instructed by Rule 134.401(b)(2)(A)."

Responses Submitted by: Harris & Harris

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
April 24, 2007 through April 27, 2007	Inpatient Hospital Services	$179,734.76	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 31 *Texas Register* 10314, applicable to requests filed on or after January 15, 2007, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
3. 28 Texas Administrative Code §134.1, 31 *Texas Register* 3561, effective May 2, 2006, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- P8F-This contracted provider or hospital has agreed to reduce this charge below fee schedule or usual and customary charges for your business. (P303) ANSI - 24
- XIP -Submit intra-operative charge record that lists each component of implants used. (X673) ANSI - 112
- ZJQ-The charge for this procedure exceeds the fee schedule allowance. (Z710)
- W1 – Workers compensation state fee schedule adjustment.
- 112 – Payment adjusted as not furnished directly to the patient and/or not documented.
- 24 – Payment for charges adjusted. Charges are covered under a capitation.
- P303-This contracted provider of hospital has agreed to reduce this charge below fee schedule or usual and customary charges for your business.
- Z710-The charge for this procedure exceeds the fee schedule allowance.
- *-This bill has been reviewed in accordance with your Fee for Service contract with First Health.
- Z989-Payment of $4238.00 was previously issued for this claim. The payment should have been $60317.37.
- * – The 'Amount Allowed' may reflect an adjustment due to repricing to applicable state fee schedules and/or exclusion of patient convenience items.
- F-Reduction according to fee guidelines.
- * – The 'AMOUNT PAYABLE' may reflect a comprehensive or per-diem adjustment due to repricing according to your contractual agreement with a preferred provider organization.

U.S. Bankruptcy Judge Michael Lynn issued a "STIPULATION AND ORDER GRANTING RELIEF FROM AUTOMATIC

STAY TO PERMIT CONTINUANCE AND ADJUDICATION OF DISPUTED WORKERS COMPENSATION CLAIMS BEFORE THE TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS," dated August 27, 2010, in the case of *In re: Renaissance Hospital – Grand Prairie, Inc. d/b/a/ Renaissance Hospital – Grand Prairie, et al.*, in the United States Bankruptcy Court for the Northern District of Texas, Fort Worth Division in Case No. 08-43775-7. The order lifted the automatic stay to allow continuance of the claim adjudication process as to the workers' compensation receivables before SOAH, effective October 1, 2010. The order specified John Dee Spicer as the Chapter 7 trustee of the debtor's estate. By letter dated October 5, 2010, Mr. Spicer provided express written authorization for Cass Burton of the law office of Burton & Hyde, PLLC, PO Box 684749, Austin, Texas 78768-4749, to be the point of contact on Mr. Spicer's behalf relating to matters between and among the debtors and the Division concerning medical fee disputes. The Division will utilize this address in all communications with the requestor regarding this medical fee dispute.

Issues

1. Does the submitted documentation support that a contractual agreement issue exists in this dispute?
2. Did the audited charges exceed $40,000.00?
3. Did the admission in dispute involve unusually extensive services?
4. Did the admission in dispute involve unusually costly services?
5. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The division received supplemental information as noted in the position summaries above. The supplemental information was shared among the parties as appropriate. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges ***in this case*** exceed $40,000; whether the admission and disputed services ***in this case*** are unusually extensive; and whether the admission and disputed services ***in this case*** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection…" 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. The insurance carrier reduced or denied disputed services with reason codes "P8F, P303, and 24." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines
2. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "…to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "…Audited charges are those charges which remain after a bill review by the insurance carrier has been performed…" Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal $320,069.51. The Division concludes that the total audited charges exceed $40,000.
3. In its original position statement, the requestor asserts that "This bill should have been audited and reimbursed per the Stop-Loss reimbursement factor and methodology per the criteria as defined in TDI-DWC rule 134.401(c)(6)(A)." 28 Texas Administrative Code §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that "This stop-loss threshold is established to ensure

compensation for unusually extensive services required during an admission." The Third Court of Appeals' November 13, 2008 opinion states that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." The requestor's original position statement failed to discuss the particulars of the admission in dispute that may constitute unusually extensive services. In its supplemental position statement, the requestor considered the Courts' final judgment. In regards to whether the services were unusually extensive, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually extensive services. The requestor's supplemental position statement asserts, that "The services rendered to [Claimant] were unusually costly and extensive…because: Complications. Multiple Surgeries." The requestor's position that this admission is unusually extensive due to surgical procedures and complications fails to meet the requirements of §134.401(c)(2)(C) because the requestor failed to demonstrate how the services in dispute were unusually extensive in relation to similar spinal surgeries or admissions. The division concludes that the requestor failed to meet the requirements of 28 Texas Administrative Code §134.401(c)(2)(C).

4. 28 Texas Administrative Code §134.401(c)(6) states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor in its supplemental position summary states:

> Admission outside of the ordinary when compared to system-wide survey of Texas inpatient admission in 2005. Unusually extensive services were provided during [Claimant's] hospital stay as indicated by the cost of this admission when compared to system-wide averages in the State of Texas. Data for all inpatient admissions in the Texas workers' compensation system was collected by the Department for 2005, 2006, 2007, 2008, and 2009. In 2007, the average bill for an inpatient admission was $39,766.32 and the average amount paid was $14,529.00. [Claimant's] admission was well outside of the ordinary when comparing the billed amount of $320,069.51 with system norms. It is even outside of the ordinary when considering the amount the carrier has already paid, $60,317.37, in light of the system averages. Of note, a principal diagnosis of 997.5 was rare in 2007; there were only two bills out of 9,703 identifying 997.5 as the principal diagnosis code. [Claimant] was the only hospital admission involving a principal diagnosis code of 997.5 and a principal procedure code of 81.06. When compared to admissions system-wide [Claimant's] admission was out of the ordinary.

The division notes that the audited charges of $88,140.65 are discussed above as a separate and distinct factor pursuant to 28 Texas Administrative Code §134.401(c)(6)(A)(i). The requestor asserts that because the amount ***billed charges*** exceeds the average for the same principal diagnosis and procedure codes, the ***cost*** of the services is therefore "out of the ordinary." Although the requestor lists and quantifies ***billing*** data, the requestor fails to list or quantify the ***costs*** associated with the disputed services. In the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276, the division concluded that "hospital charges are not a valid indicator of a hospital's costs of providing services."

The requestor further states:

> The costs were front-loaded**.** The cost associated with the hospital's services in this case are front loaded-i.e. the injured employee underwent complicated surgical procedures requiring an investment in skilled professionals and advanced facilities and medical equipment.

The requestor does not list or quantify the costs associated with these resources in relation to the disputed services, nor does the requestor provide documentation to support a reasonable comparison between the resources required for the spinal surgery. Therefore, the requestor fails to demonstrate that the resources used in this particular admission are unusually costly when compared to resources used in other types of surgeries.

The division concludes that the billed charges for the services do not represent the cost of providing those services. The requestor fails to demonstrate that the hospital's resources used in this particular admission are unusually costly.

For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements.* The Division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

- Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay

(LOS) for admission…" Review of the submitted documentation finds that the length of stay for this admission was one surgical day and two ICU/CCU; therefore the standard per diem amounts of $1,118.00 and $1,560.00 apply respectively. The per diem rates multiplied by the allowable days result in a total allowable amount of $4,238.00.

- 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)." A review of the submitted medical bill indicates that the requestor billed revenue code 278 for Implants at $195,247.41. The medical documentation provided finds that although the requestor submitted purchase orders to support what the requestor was charged by the supplier for the implantables, there was no documentation found to support the amounts that the requestor paid for the implantables. The division finds that the cost to the hospital for the implantables billed under revenue code 278 cannot be established; therefore no reimbursement can be recommended for these items.

The division concludes that the total allowable for this admission is $4,238.00. The respondent paid $60,317.37. Based upon the documentation submitted, no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount,* and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		3/28/2013
Signature	Medical Fee Dispute Resolution Officer	Date
		3/28/2013
Signature	Health Care Business Management Director	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.